		FOR OHF USE					

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0022905

Facility Name: JOLIET TERRACE

Address: 2236 MCDONOUGH (Number) JOLIET (City) 60436 (Zip Code)

County: WILL

Telephone Number: (847) 647 - 5795 **Fax #** (847) 674 - 5794

IDPA ID Number: 36-2883283

Date of Initial License for Current Owners: 10/01/76

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust	X	Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2001 to 12/31/2001 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) MORRIS ESFORMES
(Title) GENERAL PARTNER

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number JOLIET TERRACE # 0022905 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	120	Intermediate (ICF)	120	43,800	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	120	TOTALS	120	43,800	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	39,490	2,075	418	41,983	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	39,490	2,075	418	41,983	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.85%

D. How many bed-hold days during this year were paid by Public Aid?
1,242 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 10/01/76

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number JOLIET TERRACE # 0022905 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	A. General Services											
1	Dietary	163,352	12,436	6,188	181,976		181,976	0	181,976			1
2	Food Purchase		154,853		154,853		154,853	(469)	154,384			2
3	Housekeeping	126,423	14,854	0	141,277		141,277	0	141,277			3
4	Laundry	44,656	13,514	1,331	59,501		59,501	0	59,501			4
5	Heat and Other Utilities			65,473	65,473		65,473	310	65,783			5
6	Maintenance	69,135	11,466	21,566	102,167		102,167	10,403	112,570			6
7	Other (specify):*			7,817	7,817		7,817	89	7,906			7
8	**TOTAL General Services**	403,566	207,123	102,375	713,064	0	713,064	10,333	723,397			8
	B. Health Care and Programs											
9	Medical Director	0		4,000	4,000		4,000	0	4,000			9
10	Nursing and Medical Records	894,489	37,899	14,775	947,163		947,163	0	947,163			10
10a	Therapy	49,294		4,426	53,720		53,720	0	53,720			10a
11	Activities	61,308	3,711	2,904	67,923		67,923	0	67,923			11
12	Social Services	55,060		1,536	56,596		56,596	0	56,596			12
13	Nurse Aide Training			0	0		0	0	0			13
14	Program Transportation			0	0		0	0	0			14
15	Other (specify):*				0		0	0	0			15
16	**TOTAL Health Care and Programs**	1,060,151	41,610	27,641	1,129,402	0	1,129,402	0	1,129,402			16
	C. General Administration											
17	Administrative	77,835		365,750	443,585		443,585	(332,402)	111,183			17
18	Directors Fees			0	0		0	0	0			18
19	Professional Services			91,087	91,087		91,087	(231)	90,856			19
20	Dues, Fees, Subscriptions & Promotions			23,121	23,121		23,121	(12,381)	10,740			20
21	Clerical & General Office Expenses	79,330	12,388	100,848	192,566		192,566	(55,389)	137,177			21
22	Employee Benefits & Payroll Taxes			258,717	258,717		258,717	0	258,717			22
23	Inservice Training & Education			2,036	2,036		2,036	75	2,111			23
24	Travel and Seminar			26	26		26	0	26			24
25	Other Admin. Staff Transportation			14,525	14,525		14,525	522	15,047			25
26	Insurance-Prop.Liab.Malpractice			67,599	67,599		67,599	2,698	70,297			26
27	Other (specify):*			128,122	128,122		128,122	(120,899)	7,223			27
28	**TOTAL General Administration**	157,165	12,388	1,051,831	1,221,384	0	1,221,384	(518,007)	703,377			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,620,882	261,121	1,181,847	3,063,850	0	3,063,850	(507,674)	2,556,176			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number JOLIET TERRACE #0022905 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			65,049	65,049		65,049	(12,177)	52,872			30
31	Amortization of Pre-Op. & Org.			2,424	2,424		2,424	0	2,424			31
32	Interest			96,264	96,264		96,264	1,470	97,734			32
33	Real Estate Taxes			30,383	30,383		30,383	700	31,083			33
34	Rent-Facility & Grounds				0		0	0	0			34
35	Rent-Equipment & Vehicles			35,778	35,778		35,778	3,339	39,117			35
36	Other (specify):* **OFFICE RENT**			9,000	9,000		9,000	(9,000)	0			36
37	**TOTAL Ownership**			238,898	238,898	0	238,898	(15,668)	223,230			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers				0		0	0	0			39
40	Barber and Beauty Shops				0		0	0	0			40
41	Coffee and Gift Shops				0		0	0	0			41
42	Provider Participation Fee			65,700	65,700		65,700	0	65,700			42
43	Other (specify):*				0		0	0	0			43
44	**TOTAL Special Cost Centers**	0	0	65,700	65,700	0	65,700	0	65,700			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,620,882	261,121	1,486,445	3,368,448	0	3,368,448	(523,342)	2,845,106			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number JOLIET TERRACE # 0022905 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(13,502)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(469)	2		13
14	Non-Care Related Interest	0	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees	0	20		17
18	Fines and Penalties	0	21		18
19	Entertainment	0	20		19
20	Contributions	(10,737)	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers	(8,000)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(128,122)	27		24
25	Fund Raising, Advertising and Promotional	(1,206)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(1,028)	20		28
29	Other-Attach Schedule SEE PAGE 5A	(174)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (163,238)		$ 0	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(360,104)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (360,104)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (523,342)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

JOLIET TERRACE

ID# 0022905

Report Period Beginning: 01/01/2001

Ending: 12/31/2001

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ 7826	6	1
2	MARKETING SALARIES	(6,000)	21	2
3	STAFF DEVELOPMENT	(2,000)	21	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(174)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number JOLIET TERRACE # 0022905 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(469)	0	0	0	0	0	0	0	0	0	0	(469)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	310	0	0	0	0	0	0	0	310	5
6	Maintenance	7,826	0	1,712	865	0	0	0	0	0	0	0	10,403	6
7	Other (specify):*	0	0	89	0	0	0	0	0	0	0	0	89	7
8	**TOTAL General Services**	7,357	0	1,801	1,175	0	0	0	0	0	0	0	10,333	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(332,402)	0	0	0	0	0	0	0	0	0	(332,402)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(8,000)	371	7,325	73	0	0	0	0	0	0	0	(231)	19
20	Fees, Subscriptions & Promotions	(12,971)	0	590	0	0	0	0	0	0	0	0	(12,381)	20
21	Clerical & General Office Expenses	(8,000)	5,747	(53,444)	308	0	0	0	0	0	0	0	(55,389)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	75	0	0	0	0	0	0	0	0	75	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	392	130	0	0	0	0	0	0	0	0	522	25
26	Insurance-Prop.Liab.Malpractice	0	672	1,946	80	0	0	0	0	0	0	0	2,698	26
27	Other (specify):*	(128,122)	2,411	4,812	0	0	0	0	0	0	0	0	(120,899)	27
28	**TOTAL General Administration**	(157,093)	(322,809)	(38,566)	461	0	0	0	0	0	0	0	(518,007)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(149,736)	(322,809)	(36,765)	1,636	0	0	0	0	0	0	0	(507,674)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number JOLIET TERRACE # 0022905 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(13,502)	258	330	737	0	0	0	0	0	0	0	(12,177)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	360	1,110	0	0	0	0	0	0	0	1,470	32
33	Real Estate Taxes	0	0	0	700	0	0	0	0	0	0	0	700	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	1,128	2,211	0	0	0	0	0	0	0	0	3,339	35
36	Other (specify):*	0	0	0	(9,000)	0	0	0	0	0	0	0	(9,000)	36
37	**TOTAL Ownership**	(13,502)	1,386	2,901	(6,453)	0	0	0	0	0	0	0	(15,668)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(163,238)	(321,423)	(33,864)	(4,817)	0	0	0	0	0	0	0	(523,342)	45

Facility Name & ID Number JOLIET TERRACE # 0022905 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SCHEDULE ATTACHED		SCHEDULE ATTACHED		EKS MANAGEMENT	LINCOLNWOOD	BOOKKEEPING
				EMI ENTERPRISES	LINCOLNWOOD	MGMT CONSULTA
				IME REALTY	LINCOLNWOOD	HOME OFFICE

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	MANAGEMENT FEES	$ 345,000	EMI ENTERPRISES		$	$ (345,000)	1
2	V								2
3	V								3
4	V	17	OFFICERS SALARY				12,598	12,598	4
5	V	19	ACCOUNTING FEES				371	371	5
6	V	21	OFFICE EXPENSE				5,747	5,747	6
7	V	25	TRANSPORTATION				392	392	7
8	V	26	INSURANCE				672	672	8
9	V	27	EMPLOYEE BENEFITS				2,411	2,411	9
10	V	30	DEPRECIATION				258	258	10
11	V	35	AUTO LEASE				1,128	1,128	11
12	V								12
13	V								13
14	Total			$ 345,000			$ 23,577	$ * (321,423)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number JOLIET TERRACE # 0022905 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V		21	BOOKKEEPING	$ 82,080	EKS MANAGEMENT, INC		$	$ (82,080)	15
16	V									16
17	V									17
18	V		6	PAINTING /DECORATING				1,712	1,712	18
19	V		7	SCAVENGER				89	89	19
20	V		19	PROFESSIONAL FEES				7,325	7,325	20
21	V		20	WANT ADS/BACKGR CKS				590	590	21
22	V		21	OFFICE EXPENSE				28,636	28,636	22
23	V		23	SEMINARS				75	75	23
24	V		25	TRANSPORTATION				130	130	24
25	V		26	INSURANCE				1,946	1,946	25
26	V		27	EMPLOYEE BENEFITS				4,812	4,812	26
27	V		30	DEPRECIATION				330	330	27
28	V		32	INTEREST-INSUR.FIN.				360	360	28
29	V		35	EQUIPMENT RENT				2,211	2,211	29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$ 82,080			$ 48,216	$ * (33,864)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number JOLIET TERRACE # 0022905 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V		36	OFFICE RENT	$ 9,000	IME REALTY CORP.		$	$ (9,000)	15
16	V									16
17	V									17
18	V		5	UTILITIES				310	310	18
19	V		6	REPAIRS & MAINTENANCE				865	865	19
20	V		19	PROFESSIONAL FEES				73	73	20
21	V		21	OFFICE EXPENSE				308	308	21
22	V		26	INSURANCE				80	80	22
23	V		30	DEPRECIATION				737	737	23
24	V		32	INTEREST				1,110	1,110	24
25	V		33	RE TAX				700	700	25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$ 9,000			$ 4,183	$ * (4,817)	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number JOLIET TERRACE # 0022905 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	BERNARD COHEN	GENERAL PARTNE	ADMINISTRATION		SCHEDULE ATTACHED			MGMT FEE	$ 20,750	17-3	1
2	MORRIS ESFORMES	GENERAL PARTNE	ADMINISTRATION					SALARY	12,598	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 33,348		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number JOLIET TERRACE # 0022905 Report Period Beginning: 01/01/2001 Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: EMI ENTERPRISES
Street Address: 3737 W. ARTHUR
City / State / Zip Code: LINCOLNWOOD, IL 60718
Phone Number: (847) 674 - 1946
Fax Number: (847) 674 - 1962

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	OFFICERS SALARY	PATIENT DAYS	616,513	11	$ 185,000	$ 185,000	41,983	$ 12,598	1
2	19	ACCOUNTING FEES	PATIENT DAYS	616,513	11	5,451		41,983	371	2
3	21	OFFICE EXPENSE	PATIENT DAYS	616,513	11	84,399	60,672	41,983	5,747	3
4	25	TRANSPORTATION	PATIENT DAYS	616,513	11	5,763		41,983	392	4
5	26	INSURANCE	PATIENT DAYS	616,513	11	9,863		41,983	672	5
6	27	EMPLOYEE BENEFITS	PATIENT DAYS	616,513	11	35,399		41,983	2,411	6
7	30	DEPRECIATION	PATIENT DAYS	616,513	11	3,788		41,983	258	7
8	35	AUTO LEASE	PATIENT DAYS	616,513	11	16,569		41,983	1,128	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 346,232	$ 245,672		$ 23,577	25

Facility Name & ID Number JOLIET TERRACE # 0022905 Report Period Beginning: 01/01/2001 Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: EKS MGMT,
Street Address: 3737 W. ARTHUR
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 674 - 1946
Fax Number: (847) 674 - 1962

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	PAINTING / DECORATING	PATIENT DAYS	616,513	11	$ 25,141	$	41,983	$ 1,712	1
2	7	SCAVENGER	PATIENT DAYS	616,513	11	1,310		41,983	89	2
3	19	PROFESSIONAL FEES	PATIENT DAYS	616,513	11	107,563	91,129	41,983	7,325	3
4	20	WANT ADS	PATIENT DAYS	616,513	11	8,660		41,983	590	4
5	21	OFFICE EXPENSE	PATIENT DAYS	616,513	11	420,511	316,407	41,983	28,636	5
6	23	SEMINARS	PATIENT DAYS	616,513	11	1,100		41,983	75	6
7	25	TRANSPORTATION	PATIENT DAYS	616,513	11	1,912		41,983	130	7
8	26	INSURANCE	PATIENT DAYS	616,513	11	28,579		41,983	1,946	8
9	27	EMPLOYEE BENEFITS	PATIENT DAYS	616,513	11	70,657		41,983	4,812	9
10	30	DEPRECIATION	PATIENT DAYS	616,513	11	4,837		41,983	330	10
11	32	INTEREST-INSUR. FIN.	PATIENT DAYS	616,513	11	5,286		41,983	360	11
12	35	EQUIPMENT RENT	PATIENT DAYS	616,513	11	32,463		41,983	2,211	12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 708,019	$ 407,536		$ 48,216	25

Facility Name & ID Number JOLIET TERRACE # 0022905 Report Period Beginning: 01/01/2001 Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: IME REALTY CORP.
Street Address: 3737 W. ARTHUR
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 674 - 1946
Fax Number: (847) 674 - 1962

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	INCOME	203,249	11	$ 6,990	$	9,000	$ 310	1
2	6	REPAIRS & MAINTENANCE	INCOME	203,249	11	19,525		9,000	865	2
3	19	PROFESSIONAL FEES	INCOME	203,249	11	1,650		9,000	73	3
4	21	OFFICE EXPENSE	INCOME	203,249	11	6,958		9,000	308	4
5	26	INSURANCE	INCOME	203,249	11	1,798		9,000	80	5
6	30	DEPRECIATION	INCOME	203,249	11	16,647		9,000	737	6
7	32	INTEREST	INCOME	203,249	11	25,074		9,000	1,110	7
8	33	RE TAX	INCOME	203,249	11	15,815		9,000	700	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 94,457	$		$ 4,183	25

Facility Name & ID Number JOLIET TERRACE # 0022905 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	LINCOLNWOOD FUNDING		X	MORTGAGE	$5,173.00	08/01/95	$ 1,795,000	$	07/31/75	PRIME+	$ 95,164	1
2	LINCOLNWOOD FUNDING		X	LETTER OF CREDIT							1,100	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8	RELATED PARTY										1,470	8
9	TOTAL Facility Related				$5,173.00		$ 1,795,000	$ 0			$ 97,734	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$ 0	$ 0			$ 0	14
15	TOTALS (line 9+line14)						$ 1,795,000	$ 0			$ 97,734	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number JOLIET TERRACE # 0022905 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 31,500	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 30,783	2
3. Under or (over) accrual (line 2 minus line 1).		$ (717)	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 31,100	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 30,383	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	32,125	8
	1997	32,600	9
	1998	32,235	10
	1999	31,203	11
	2000	30,783	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2000 TAX BILL.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME JOLIET TERRACE COUNTY WILL

FACILITY IDPH LICENSE NUMBER 0022905

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	30-07-18-300-016-0000	NURSING HOME	$ 30,783.14	$ 30,783.14
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 30,783.14	$ 30,783.14

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number JOLIET TERRACE # 0022905 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 26,836 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories _____

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME		1976	$ 100,000	1
2					2
3	TOTALS			$ 100,000	3

Facility Name & ID Number JOLIET TERRACE # 0022905 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	120		1976	1976	$ 1,233,000	$ 12,330	25	$ 12,330	$	$ 1,233,000	4
5											5
6											6
7	RELATED PARTY					604		604			7
8											8
	Improvement Type**										
9	BUILDING IMPROVEMENTS			1979	3,802		10			3,802	9
10	BUILDING IMPROVEMENTS			1980	10,532		3			10,532	10
11	BUILDING IMPROVEMENTS			1980	7,500		10			7,500	11
12	BUILDING IMPROVEMENTS			1982	54,503	1,730	31.5	1,730		22,418	12
13	BUILDING IMPROVEMENTS			1983	2,495		10			2,495	13
14	BUILDING IMPROVEMENTS			1989	8,100	540	15	540		6,480	14
15	BUILDING IMPROVEMENTS			1990	19,140	608	20	957	349	10,049	15
16	BUILDING IMPROVEMENTS			1991	5,335	169	20	267	98	2,536	16
17	BUILDING IMPROVEMENTS			1992	17,257	549	31.5	549		4,704	17
18	BUILDING IMPROVEMENTS			1992	11,861	791	15	791		6,723	18
19	BUILDING IMPROVEMENTS			1993	4,065	129	31.5	129		1,008	19
20	BUILDING IMPROVEMENTS			1993	14,238	366	39	366		2,713	20
21	BUILDING IMPROVEMENTS			1994	5,200	133	39	133		804	21
22	FLOORING INSTALL			1995	9,823	252	39	252		985	22
23	ROOFING			1995	12,675	325	39	325		1,177	23
24	TILES			1996	15,503	397	39	397		1,439	24
25	FLOOR TILES			1998	23,132	593	39	593		1,489	25
26	ROOFING			1999	17,100	438	39	438		786	26
27	BLINDS/WALLCOVERING/WINDOW TREATMENTS			2000	19,897	4,873	20	995	(3,878)	1,492	27
28	COVE BASE			2000	2,679	97	27.5	97		174	28
29	SPRIKLER HEADS			2000	4,300	156	27.5	156		189	29
30	AIR CONDITIONS			2001	1,887	31	27.5	31		31	30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number JOLIET TERRACE # 0022905 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,504,024	$ 25,111		$ 21,680	$ (3,431)	$ 1,322,526	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number JOLIET TERRACE # 0022905 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 313,741	$ 37,712	$ 29,763	$ (7,949)	5-10	$ 141,512	71
72	Current Year Purchases	14,152	2,830	708	(2,122)	10	708	72
73	Fully Depreciated Assets	281,700			0		281,700	73
74	RELATED PARTY		721	721	0			74
75	TOTALS	$ 609,593	$ 41,263	$ 31,192	$ (10,071)		$ 423,920	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$ 0		$	76
77							0			77
78							0			78
79							0			79
80	TOTALS			$ 0	$ 0	$ 0	$ 0		$ 0	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 2,213,617	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 66,374	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 52,872	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (13,502)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,746,446	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 18,882 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	ACTIVITY & MAINT.	2001 CHEVY VAN	$ 699.00	$ 7,171	17
18	ADNINISTRATIVE	2001 BMW	897.00	7,695	18
19	FACILITY	1998 CHEVROLET VAN	650.00	650	19
20	FACILITY	1998 TOYOTA	300.00	1,380	20
21	TOTAL		$ 2,546.00	$ 16,896	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number JOLIET TERRACE # 0022905 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$ 0
2	Books and Supplies				0
3	Classroom Wages (a)				0
4	Clinical Wages (b)				0
5	In-House Trainer Wages (c)				0
6	Transportation				0
7	Contractual Payments				0
8	Nurse Aide Competency Tests				0
9	TOTALS	$ 0	$ 0	$ 0	$ 0
10	SUM OF line 9, col. 1 and 2 (e)	$ 0			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number JOLIET TERRACE # 0022905 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2001 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 118,183	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	857,463		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	91,734		6
7	Other Prepaid Expenses	1,626		7
8	Accounts Receivable (owners or related parties)	560,230		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,629,236	$ 0	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	301,643		11
12	Long-Term Investments			12
13	Land	100,000		13
14	Buildings, at Historical Cost	1,233,000		14
15	Leasehold Improvements, at Historical Cost	271,024		15
16	Equipment, at Historical Cost	609,593		16
17	Accumulated Depreciation (book methods)	(1,840,303)		17
18	Deferred Charges	33,015		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 707,972	$ 0	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,337,208	$ 0	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 119,592	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	200,000		29
30	Accrued Salaries Payable	52,872		30
31	Accrued Taxes Payable (excluding real estate taxes)	28,333		31
32	Accrued Real Estate Taxes(Sch.IX-B)	31,100		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 431,897	$ 0	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,448,420		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,448,420	$ 0	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,880,317	$ 0	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 456,891	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,337,208	$ 0	48

***(See instructions.)**

Facility Name & ID Number JOLIET TERRACE # 0022905 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 395,299	1
2	Restatements (describe):		2
3	IL REPLACEMENT TAX	(3,766)	3
4	PRIOR YEAR ADJUSTMENT	(56,131)	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 335,402	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	243,051	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(121,562)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 121,489	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 0	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 456,891	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number JOLIET TERRACE # 0022905 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,582,792	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,582,792	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 0	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 0	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	28,707	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 28,707	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 0	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,611,499	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	713,064	31
32	Health Care	1,129,402	32
33	General Administration	1,221,384	33
	B. Capital Expense		
34	Ownership	238,898	34
	C. Ancillary Expense		
35	Special Cost Centers	0	35
36	Provider Participation Fee	65,700	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,368,448	40
41	**Income before Income Taxes (line 30 minus line 40)****	243,051	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 243,051	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number JOLIET TERRACE # 0022905 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,655	1,663	$ 41,435	$ 24.92	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,872	3,092	56,671	18.33	3
4	Licensed Practical Nurses	17,693	18,410	304,554	16.54	4
5	Nurse Aides & Orderlies	46,372	48,442	451,299	9.32	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,574	4,139	49,294	11.91	8
9	Activity Director					9
10	Activity Assistants	7,661	7,913	61,308	7.75	10
11	Social Service Workers	4,987	5,366	55,060	10.26	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	17,973	19,429	163,352	8.41	15
16	Dishwashers					16
17	Maintenance Workers	6,419	6,795	69,135	10.17	17
18	Housekeepers	16,869	17,825	126,423	7.09	18
19	Laundry	5,855	6,265	44,656	7.13	19
20	Administrator	2,260	2,260	77,835	34.44	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,484	7,928	79,330	10.01	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) SEE ATTACHED	2,052	2,210	40,530	18.34	33
34	TOTAL (lines 1 - 33)	143,726	151,737	$ 1,620,882 *	$ 10.68	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 6,188	1-3	35
36	Medical Director	O	4,000	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	1,200	10-3	38
39	Pharmacist Consultant	H	4,620	10-3	39
40	Physical Therapy Consultant	L	2,410	10a-3	40
41	Occupational Therapy Consultant	Y	2,016	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	F	2,904	11-3	44
45	Social Service Consultant	E	1,536	12-3	45
46	Other(specify)	E			46
47	PSYCHO-SOCIAL	S	384	10-3	47
48					48
49	TOTAL (lines 35 - 48)		$ 25,258		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 3,705		50
51	Licensed Practical Nurses		485		51
52	Nurse Aides		1,356		52
53	TOTAL (lines 50 - 52)		$ 5,546		53

Facility Name & ID Number JOLIET TERRACE # 0022905 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
	ADMIN		$ 77,835
	ASST ADMIN		0
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 77,835

B. Administrative - Other

Description	Amount
EMI ENTERPRISES	$ 345,000
BERNARD COHEN	20,750
TOTAL (agree to Schedule V, line 17, col. 3)	$ 365,750
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
ALPHA DATA SYSTEM	DATA PROCESSING	$ 3,322
MAXX SOURCE	DATA PROCESSING	1,625
MID AMER PROGRAMMING	DATA PROCESSING	1,320
NURSING CARE SYSTEM	DATA PROCESSING	5,455
APLHA CPX	DATA PROCESSING	22
KBKB, LTD	ACCOUNTING	11,100
McBRIDE, BAKER	LEGAL	38,426
LAWRENCE SCHWARTZ	LEGAL	26,000
PERSONNEL PLANNER	UC CONSULTANT	907
OAK FOREST	PSYCHO CONSULTANT	200
LINCOLNWOOD FUNDING	REMARKETING	2,710
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 91,087

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 47,465
Unemployment Compensation Insurance	27,733
FICA Taxes	123,703
Employee Health Insurance	50,087
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	4,453
EMPLOYEE PHYSICAL EXAMS	0
PENSION/PROFIT SHARING PLANS	5,276
CHICAGO HEAD TAX	0
INSURANCE - EXECUTIVE LIFE	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 258,717

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	6,338
Health Care Worker Background Check	0
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	2,234
TRUST FEES/CONTRIBUTIONS	8,825
RELATED PARTY	590
DUES & SUBSCRIPTIONS	3,124
LICENSES & PERMITS	488
TRUST FEES/CONTRIBUTIONS	(8,825)
Less: Public Relations Expense	(0)
Non-allowable advertising	(1,206)
Yellow page advertising	(1,028)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 10,740

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	26
Seminar Expense	
EDUCATION & SEMINAR	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 26

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number JOLIET TERRACE # 0022905 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	PAINT/DECORATING	1998	$ 2,262	3	$ 377	$ 754	$ 754	$ 377	$	$	$	$	$
2	PAINT/DECORATING	1999	22,346	3		3,724	7,449	7,449	3,724				
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 24,608		$ 377	$ 4,478	$ 8,203	$ 7,826	$ 3,724	$	$	$	$

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL COUNCIL ON LONG TERM $2474**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **1,185** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **65,700**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.

Facility Name & ID#: JOLIET TERRACE **#0022905** **Report Period Beginning: 01/01/2001** **Ending: 12/31/2001**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	6,188	
	REPAIRS & MAINTENANCE		0	
			0	6,188
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		1,331	
			0	1,331
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		25,169	
	ELECTRICITY		31,513	
	WATER		8,791	
	CABLE TV - LOBBY		0	
			0	65,473
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		4,408	
	PAINTING & DECORATING		0	
	BUILDING REPAIRS		8,898	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		4,318	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		1,022	
	FIRE SERVICE		2,920	
			0	
			0	
			0	21,566
7	**OTHER**			
	SCAVENGER		6,201	
	SECURITY SERVICE		1,616	7,817
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	4,000	4,000

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	5,546	
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	384	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	0	
	PHARMACY CONSULTANT	XVIII B 39-2	4,620	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	1,200	
	DENTAL SERVICES		3,025	
			0	14,775
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES			
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	2,410	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	2,016	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	4,426
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	2,904	
			0	2,904
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	1,536	
	SOCIAL WORKER	XVIII B 45-2	0	
			0	1,536
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number JOLIET TERRACE **#0022905** **Report Period Beginning: 01/01/2001** **Ending: 12/31/2001**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		0	0
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	365,750	365,750
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	11,744	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	79,343	
			0	91,087
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	1,206	
	EMPLOYEE WANT ADS	XIX F	6,338	
	CONTRIBUTIONS	VI 20 XIX F	425	
	DUES & SUBSCRIPTIONS	XIX F	3,124	
	LICENSES & PERMITS	XIX F	688	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	1,028	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	10,312	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	0	23,121
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES		622	
	EQUIPMENT REPAIR & MAINTENANCE		3,840	
	OUTSIDE CLERICAL SERVICES		82,080	
	PENALTIES / OVERDRAFT CHARGES	VI 18	0	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		12,306	
	MESSENGER SERVICE		0	
	STAFF DEVELOPMENT		2,000	100,848

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	123,703	
	UNEMPLOYMENT COMPENSATION	XIX D	27,733	
	WORKERS COMPENSATION INSURANC	XIX D	47,465	
	HOSPITALIZATION INSURANCE	XIX D	50,087	
	EMPLOYEE BENEFITS - OTHER	XIX D	4,453	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	5,276	
	CHICAGO HEAD TAX	XIX D	0	258,717
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		2,036	2,036
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G		
	TRAVEL	XIX G	26	
			0	
			0	26
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		14,525	14,525
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		67,599	67,599
27	**OTHER**			
	BAD DEBTS	VI 24	128,122	
			0	128,122

GRAND TOTAL COLUMN 3 OTHER 1,181,847

JOLIET TERRACE
EMPLOYEE MEAL RECLASSIFICATION
12/31/2001

TOTAL FOOD PURCHASE	154,853	PATIENT MEALS	125949
LESS SALES TAX	(469)	ADD EMPLOYEE MEALS	0
NET FOOD	155322	TOTAL MEALS/YEAR	125949
TOTAL PATIENT CENSUS	41,983	NET FOOD	155322
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	125949
TOTAL PATIENT MEALS	125949	COST PER MEAL	1.23
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY	0		
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	0
TOTAL EMPLOYEE MEALS	0		